ILLINOIS WORKERS' COMPENSATION COMMISSION
MEDICAL FEE SCHEDULE
INSTRUCTIONS AND GUIDELINES

Table of Contents

Introduction and Purpose

Pursuant to Section 8.2 of the Illinois Workers' Compensation Act (820 ILCS 305/8.2; Public Act 94-277), the Illinois Workers' Compensation Commission (Commission) has promulgated a comprehensive fee schedule to establish maximum medical payments for both professional and facility fees generated on workers' compensation claims.

The maximum medical payments (also referred to as "fee schedule amounts") were formulated by determining the 90% of the 80th percentile from health care provider fees from August 1, 2002 through August 1, 2004. Fee schedule amounts were established for 29 geo-zips (the three-digit zip code where the treatment was provided) in Illinois. An initial 4.96% increase was applied to the fee schedule amounts (the Consumer Price Index-U (CPI-U) for the period August 1, 2004 through September 30, 2005). The Commission will automatically increase or decrease the maximum allowable payment based upon the CPI-U on an annual basis.

In addition to maximum medical payments based upon historical fee data, the Commission has set maximum medical payment amounts in a manner consistent with Section 8.2 of the Act:

1) For entire service categories (e.g., 76% of the charged amount for ambulatory surgical treatment centers) or

2) For fees within a service category where data was insufficient to establish a fee schedule amount (e.g., POC76 for a new code).

For the purposes of this fee schedule, "POC76" means reimbursement should occur at 76% of the charged amount.

The fee schedule amounts apply *only* to procedures, treatments, and services provided on or after February 1, 2006.

The fee schedule does not preclude any privately and independently negotiated rates or agreements between a provider and a carrier, or a provider and an employer, that are negotiated for the purposes of providing services covered under the Illinois Workers' Compensation Act.

This document is intended to assist with fee schedule application, and to insure correct billing and reimbursement on workers' compensation medical claims. This document is NOT intended, and should not be construed, as a utilization review guide or practice manual.

Reference Materials

This schedule is in accordance with the following documents, including codes, guidelines, and modifiers:

1. *Current Procedural Terminology*, copyright, American Medical Association, 515 N. State St., Chicago, IL, 60610, Chicago, 2006.

2. *HCPCS Level II*, U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland, 21244, Baltimore, 2006.

3. *National Correct Coding Policy Manual in Comprehensive Code Sequence for Part B Medicare Carriers, Version 12.0*, U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland, 21244, Baltimore, 2006.

4. *Relative Value Guide*, copyright, American Society of Anesthesiologists, 520 North Northwest Highway, Park Ridge, Illinois, 60068-2573, Park Ridge, 2006.

5. Diagnosis-Related Group (DRG) classification system, Centers for Medicare and Medicaid Services (CMS), *Federal Register*, vol. 70, no. 155, August 2005.

Section 1. Ambulatory Surgical Treatment Center

This schedule applies to licensed ambulatory surgical treatment centers as defined by the Illinois Department of Public Health.

Any institution or building devoted primarily to the maintenance and operation of facilities for the performance of surgical procedures, as evidenced by use of the facilities by physicians or podiatrists in the performance of surgical procedures that constitutes more than 50 percent of the activities at that location.

Any place, located within an institution or building, such as a surgical suite or an operating room with related facilities in a physician's office or group practice clinic, devoted primarily to the performance of surgical procedures. This provision shall apply regardless of whether or not the institution or building in which the place is located is devoted primarily to the maintenance and operation of facilities for the performance of surgical procedures. This provision shall include any place that meets the definition of an ambulatory surgical center under the rules of the federal Centers for Medicare & Medicaid Services (CMS) (42 CFR 416). However, when such a place is located within and operated in conjunction with the offices of a single physician or podiatrist, or a group of physicians or podiatrists, it shall not be considered an ambulatory surgical treatment center, unless: it meets the definition of and has expressed an intent to apply for certification as an ambulatory surgical center under the rules of the federal CMS (42 CFR 416); or it is used by physicians or podiatrists who are not part of the practice; or it is utilized by the physicians or podiatrists for surgical procedures which constitute more than 50 percent of the activities at that location.

For the purposes of this schedule, the term "ambulatory surgical treatment center," does not include:

Hospitals: Any institution, place, building or agency required to be licensed pursuant to the Hospital Licensing Act [210 ILCS 85].

Long-term care facilities: Any person or institution required to be licensed pursuant to the Nursing Home Care Act [210 ILCS 45].

State facilities: Hospitals or ambulatory surgical treatment centers maintained by the State or any Department or agency thereof, where such department or agency has authority under law to establish and enforce standards for the hospitals or ambulatory surgical treatment centers under its management and control.

Federal facilities: Hospitals or ambulatory surgical treatment centers maintained by the federal government or agencies thereof.

Dental surgery facilities: Any place, agency, clinic, or practice, public or private, whether organized for profit or not, devoted exclusively to the performance of dental or oral surgical procedures. (Section 3(A) of the Act). (Title 77: Public Health Chapter I: Department of Public Health Subchapter b: Hospital and Ambulatory Care Facilities Part 205 Ambulatory Surgical Treatment Center Licensing Requirements Section 205.110 Definitions).

All ambulatory surgical treatment center (ASTC) fees shall be paid at 76% of charged amount, except for the following items, which will be classified as “pass-through charges” and paid at a rate of 65% of the charged amount:

- Prosthetics/orthotics
- Pacemaker
- Lens implants
- Implants
- Investigational devices
- Drugs requiring detailed coding

Charges billed under the above listed items will be at a provider's normal rates under its standard chargemaster.

For revenue code detail regarding these items, please refer to the "carve-out" information in Sections 6 and 7.

When an ASTC functions as an Independent Diagnostic Testing Facility (IDTF), and not as an ASTC, other service category fee schedules will apply where appropriate (e.g., radiology, pathology and laboratory).

Section 2. Anesthesia Services

An anesthesia fee schedule has been established using historical charge data from August 1, 2002 through August 1, 2004. The historical charge data was analyzed and formulated to establish a "conversion factor." The American Medical Association (AMA) and the American Society of Anesthesiologists (ASA) are both responsible for developing anesthesia codes and guidelines. The conversion factor is to be used in manner consistent with guidelines from these two organizations. Specifically, a conversion factor is a dollar amount that is to be used within the context of the 2006 Relative Value Guide.

A. General Guidelines

Anesthesia time begins when an anesthesiologist OR certified registered nurse anesthetist (CRNA) physically starts to prepare the patient for the induction of anesthesia in the operating room (or its equivalent) and ends when the anesthesiologist is no longer in constant attendance (when the patient is safely put under postoperative supervision).

B. Base value, physical status modifier, time units, and qualifying circumstances

The maximum fee schedule reimbursement amount for anesthesia services is determined by the following formula:

Base Value + Time Units + Modifying Units = Total Units

Total Units X Conversion Factor = Total Fee

1. All anesthesia services reported using CPT codes 00100-01999 have an assigned **Base Value** unit(s) (e.g., 00632…7 units). The base value represents the value of all usual anesthesia services administered during the service EXCEPT time and modifying factors.

   The usual anesthesia services included in the base value includes the usual pre- and postoperative visits, administration of fluids and/or blood products incident to the anesthesia care, and interruption of non-invasive monitoring (ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry). The placement of arterial central venous and pulmonary atrially catheters or the use of transesophageal echo cardiography (TEE) are not included in the base unit value.

2. All anesthesia services are reported by use of the anesthesia 5-digit procedure codes, plus the addition of a **Physical Status Modifier**. These modifying units may be added to the base values. The use of other optional modifiers may be appropriate. The unit values for the physical status modifiers are as follows:

	Unit Values
•P1 – Healthy patient……..	0
•P2 – Mild systemic disease…….....	0
•P3 – Severe systemic disease…….....	1
•P4 – Severe systemic disease—constant threat to life……	2
•P5 – Moribund patient …….	3
•P6 – Brain-dead patient/organ donor…….	0

3. **Time Units** are calculated by allowing 1.0 unit for each segment of time as is customary in the local area (e.g., 1.0 unit for each 15 minutes of anesthesia time).

4. In addition to unit amounts established by considering the base value units and time units, additional unit values may be established by reporting extraordinary circumstances (e.g., total body hypothermia). These are referred to as **Qualifying Circumstances.** Qualifying Circumstances are always reported in addition to the base value units, using the following codes:

CPT Code and Description	Unit Values
• 99100 Extreme age ……...…..	1
• 99116 Utilization of total body hypothermia ……..……	5
• 99135 Utilization of controlled hypotension	5
• 99140 Emergency conditions (specify) ……..…….……	2

Example for calculating a fee schedule reimbursement amount in geozip 606

Procedure CPT 01744:	Anesthesia for open or surgical arthroscopic procedures--elbow
Time of Anesthesia Services:	1 hour 15 minutes
Physical Status:	P1
Qualifying Circumstances:	None

Translation:

Base Value for 01744	5 units
Time (75 minutes divided by 15) +	5 units
Physical Status (P1) +	0 units
Qualifying Circumstances-none (0 units) +	0 units
Total Units =	10 units

Fee Schedule Calculation

Total Units	10 Units
Fee Schedule Conversion Factor (for geo-zip 606)	X $92.99
Maximum Fee Schedule Amount =	$929.90

C. Special Coding Situations

Special coding situations such as those involving multiple procedures, additional procedures, unusual monitoring, prolonged physician services, postoperative pain management, monitored (stand-by anesthesia), invasive anesthesia and chronic pain management services require application of the fee schedule in a manner consistent with guidelines of the ASA.

Section 3. Dental Services

All dental fees shall be paid at 76% of charged amount unless the service is billed under codes listed in this fee schedule (e.g., CPT or HCPCS).

Section 4. Emergency Room Facility

All emergency room facility fees shall be paid at 76% of charged amounts.

The 76% of charged amount reimbursement level will apply to all facility fees from any department or facility of a hospital, whether situated on or off the main hospital campus, that: (1) is licensed by the State as an emergency room or emergency department, and: (2) is held out to the public as providing care for emergency medical conditions without requiring an appointment; or during its previous calendar year, has provided at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis.

See also Hospital Outpatient Services below; all non-emergency services provided in a hospital outpatient setting are also to be paid at 76% of charged amount (e.g., radiology, laboratory and pathology, physical medicine/physical therapy).

A physician's professional service is subject to the professional services fee schedule and should be billed under the appropriate CPT code.

Section 5. HCPCS (Healthcare Common Procedure Coding System) Level II

The fee schedule will incorporate the HCPCS (Healthcare Common Procedure Coding System) Level II codes and modifiers not included in CPT.

Section 6. Hospital Inpatient Services: Standard and Trauma

The coding mechanism upon which the inpatient fee schedules are based is that of DRG (diagnosis-related group). A DRG is a code that groups patients into homogeneous classifications that demonstrate similar length-of-stay patterns and use of hospital resources.

Two hospital inpatient fee schedules have been established using historical charge data (minus charge data from eight revenue codes). The first fee schedule is the standard DRG fee schedule that will apply to the vast majority of hospital inpatient bills. The second fee schedule is the trauma DRG fee schedule that will apply to a small number of inpatient bills that involve trauma admissions at designated trauma centers.

As of the release of this fee schedule, February 1, 2006, there are 559 DRG listings. DRGs are added and deleted every October 1st, and since the Illinois Workers' Compensation Commission Fee Schedule is based on historical charge data, please note the following historical observations:

- DRGs 4, 5, 231, 514, 214, 215, 221, 222, 434-438, and 456-460 are classified as "NO LONGER VALID." Invalid DRGs shall not be used.

- DRGs 541-559 are new DRGs and are listed as "NEW CODES" in the fee schedule. New DRGs will be paid at 76% of billed charges, but are subject to some revenue code "pass-through" considerations discussed below.

General Guidelines for Standard Inpatient and Trauma Inpatient Care

A. Definition of Inpatient

Inpatient care shall be defined as when a patient is admitted to a hospital where services include, but are not limited to, bed and board, nursing services, diagnostic or therapeutic services, and medical or surgical services. Observation stays are reimbursed under the outpatient schedule.

B. Clearly Identifiable DRG

As reimbursement is based upon DRG, hospital providers must clearly identify the DRG assignment on each bill (UB-92 claim form). The DRG assignment will be made in a manner consistent with grouping practices used by the hospital when billing both government and private carriers (e.g., CMS Grouper Version 23.0). Hospitals shall list the DRG code in Box 78 on the UB-92.

C. DRG as a Global Reimbursement and Revenue Code Exceptions to Global Reimbursement

The DRG fee schedule amount reflects the maximum medical reimbursement amount for an entire inpatient hospital stay.

There are, however, eight exceptions:

- 0274 (prosthetics/orthotics)
- 0275 (pacemaker)
- 0276 (lens implants)
- 0278 (implants)
- 0540 and 545 (ambulance)
- 0624 (investigational devices)
- 0636 (drugs requiring detailed coding)

These charges are classified as "pass-through charges" and are paid at a rate of 65% of the charged amount. These revenue codes will not be covered under the DRG fee schedule amount. Once pass-through charges are identified and removed, all remaining charges are subject to the DRG fee schedule amount.

Charges billed under the above listed revenue codes shall be at a provider's normal rates under its standard chargemaster.

If the fee schedule amount defaults to 76% of charged amount, these rules will still apply. Remove all charges from the applicable revenue code line items and pay at 65% of charged amount: the remaining total charges will then be paid at 76%.

D. Cost Outliers

The Illinois Workers' Compensation Act recognizes that there are cases where the costs for treating an injured worker are unusually high in relation to other patients treated within the same assigned

DRG. This fee schedule will use the following formula to determine if cost outlier payments should be made. If, after subtracting the pass-through revenue code charges, the balance of the bill is equal to or above two times the fee schedule amount, the charged amount meets the definition of a cost outlier. The maximum reimbursement amount will be as follows: the pass-through revenue code charges are reimbursed at 65% of actual charge and the balance of the bill will be reimbursed at the fee schedule amount plus 76% of the portion of the charges that exceed the fee schedule amount. The pass-through revenue code charges shall be billed at the provider's normal rates under its standard chargemaster.

Special Guidelines for Trauma Inpatient Care

Section 8.2 of the Illinois Workers' Compensation Act specifically refers to "trauma," and the IWCC addresses this section with the Trauma Inpatient Fee Schedule. All inpatient hospital bills from state-designated Level I and Level II trauma centers (as designated by the Illinois Department of Public Health) and which contain an admission type of "5" on the UB-92 FL19[1] are subject to the Trauma Inpatient Fee Schedule (not the standard fee schedule).

All trauma admissions are subject to the same rules discussed in this section.

Section 7. Hospital Outpatient Services

The Illinois Department of Public Health defines a hospital as any institution, place, building or agency required to be licensed pursuant to the Hospital Licensing Act [210 ILCS 85].

All hospital outpatient services shall be paid at 76% of charged amount.

No fees submitted from a hospital for outpatient services will be subject to the professional services or HCPCS fee schedules.

When hospital outpatient services involve an ambulatory surgical procedure, payment will be at 76% of the charged amount, except for the following carve-out categories/revenue codes, which should be paid at 65% of charged amount.

- 0274 (prosthetics/orthotics)
- 0275 (pacemaker)
- 0276 (lens implants)
- 0278 (implants)
- 0540 and 545 (ambulance)
- 0624 (investigational devices)
- 0636 (drugs requiring detailed coding)

Charges billed under the above listed revenue codes shall be at a provider's normal rates under its standard chargemaster.

[1] UB-92 refers to uniform billing form used by hospitals. "FL" is the acronym for "form locator" and the number that immediately follows it indicates where on the UB-92 billing form the CPT/HCPCS and revenue codes are listed.

Section 8. Professional Services

The fee schedule for professional services is based on the American Medical Association Current Procedural Terminology (CPT) code set.

A. Evaluation and Management

The fee schedule defers to the guides and descriptions in the CPT in establishing the correct classification of evaluation and management services (codes 99201-99499).

Modifiers

Modifiers for evaluation and management include, but are not limited to: 21, 22, 24, 25, 32, 52, 53, 57, and 59. See the modifier chart below or refer to the CPT for further information.

B. Surgery

Please refer to the table, "Payment Guide to Global Days, Multiple Procedures, Bilateral Surgeries, Assistant Surgeons, Co-Surgeons, and Team Surgery," when determining global days and when determining which codes support applying modifiers for multiple procedures, bilateral surgeries, assistant surgeons, co-surgeons, and team surgery.

C. Radiology Services

The fee schedule provides three categories of maximum medical reimbursement for radiology codes 70010-79999:

1) Total component (sometimes referred to as "global");
2) Professional component; and
3) Technical component.

When a charge is submitted by one physician who provides *both* the technical and professional components of a radiology procedure, designated by no attached modifier, the maximum medical reimbursement will be the amount listed in the "TOTAL" column.

When a charge is submitted for a physician's interpretation and report on radiology procedure, or other professional services related to that procedure, as designated by the -26 modifier, the maximum medical reimbursement will be that listed in the "PC AMOUNT" column of the fee schedule.

When a charge is submitted for only the technical component (costs associated with equipment, supplies, technical personnel etc.), as designated by a –TC modifier, the maximum medical reimbursement will be that listed in the "TC AMOUNT" column. Note: The TC modifier is not found in the CPT book, but it is a modifier for "technical component" found in HCPCS Level II. The fee schedule recognizes and instructs the use of the –TC modifier when billing for the technical component of a radiology procedure.

Default Instructions

When the fee schedule defaults to POC76 in the "TOTAL" column, the amount paid will be 76% of the total charge. The professional and technical components will be paid at 76% of the charged

amount. (e.g., for modifier 26 - professional component, pay 76% of charged amount; for modifier TC - technical component, pay 76% of charged amount).

Modifiers

Aside from modifiers 26 and TC for the professional and technical components, other modifiers for radiology include, but are not limited to: 22, 52, 59, 76, and 77. See the modifier chart below or refer to the CPT for further information.

D. Pathology and Laboratory

The fee schedule provides three categories of maximum medical reimbursement for pathology and laboratory CPT codes 80048-89356:

1) A total fee for a service that is a combination of the technical and professional components;
2) A professional component for when a pathologist provides an opinion on, or reviews test results; and
3) A technical component.

When a charge is submitted by one physician who provides *both* the technical and professional components of a pathology or laboratory, designated by no attached modifier, the maximum medical reimbursement will be the amount listed in the "TOTAL" column.

When a charge is submitted for a physician's interpretation of a test or procedure, or other professional services related to that test or procedure, as designated by the -26 modifier, the maximum medical reimbursement will be that listed in the "PC AMOUNT" column of the fee schedule.

When a charge is submitted for only the technical component, as designated by a –TC modifier, the maximum medical reimbursement will be that listed in the "TC AMOUNT" column. Note: The TC modifier is not found in the CPT book, but it is a modifier for "technical component" found in HCPCS Level II. The fee schedule recognizes and instructs the use of the –TC modifier when billing for the technical component of a pathology or laboratory procedure.

Default Instructions

When the fee schedule defaults to POC76 in the "TOTAL" column, the amount paid will be 76% of the total charge. The professional and technical components will be paid at 76% of the charged amount. (e.g., for modifier 26 - professional component, pay 76% of charged amount; for modifier TC - technical component, pay 76% of charged amount).

Modifiers

Aside from modifiers 26 and TC for the professional and technical components, other modifiers for pathology include, but are not limited to: 22, 52, 59, 90, 91. See the modifier chart below or refer to the CPT book for further information.

E. Medicine Services

The fee schedule provides three categories of maximum medical reimbursement for medicine codes 90281-99602:

1) Total component (sometimes referred to as "global");
2) Professional component; and
3) Technical component.

When a charge is submitted by one physician who provides *both* the technical and professional components of a medicine code, designated by no attached modifier, the maximum medical reimbursement will be the amount listed in the "TOTAL" column.

When a charge is submitted for a physician's professional component of a medicine code, as designated by the -26 modifier, the maximum medical reimbursement will be that listed in the "PC AMOUNT" column of the fee schedule.

When a charge is submitted for only the technical component, as designated by a –TC modifier, the maximum medical reimbursement will be that listed in the "TC AMOUNT" column. Note: The TC modifier is not found in the CPT book, but it is a modifier for "technical component" found in HCPCS Level II. The fee schedule recognizes and instructs the use of the –TC modifier when billing for the technical component of a medicine procedure.

Default Instructions

When the fee schedule defaults to POC76 in the "TOTAL" column, the amount paid will be 76% of the total charge. The professional and technical components will be paid at 76% of the charged amount. (e.g., for modifier 26 - professional component, pay 76% of charged amount; for modifier TC - technical component, pay 76% of charged amount).

Modifiers

Aside from modifiers 26 and TC for the professional and technical components, other modifiers for medicine include, but are not limited to: 22, 32, 51, 52, 53, 55, 56, 57, 58, 59, 76, 77, 78, 79, 90, 99.52, 59, 90, 91. See the modifier chart below or refer to the CPT for further information.

F. Modifiers

Modifier	**AMA Description/Illinois Instructions** Due to copyright restrictions, the actual modifier descriptions are not listed. Please refer to *Current Procedural Terminology (CPT®),* American Medical Association, 2006.	**Payment Policy/ Documentation Requirements**
21	Please refer to CPT.	125 percent of fee schedule amount. Appropriate documentation includes cover letter detailing how evaluation exceeded highest-level code.

Modifier	AMA Description/Illinois Instructions	Payment Policy/ Documentation Requirements
22	Please refer to CPT. Specific instructions for the Illinois fee schedule: Clinical examples include, but are NOT limited to following: 1. Mangled Extremity – Complex injury to limb (arm/leg) with potential for limb loss. Neurovascular, soft tissue, bone disruption consistent with intent of guideline. i.e., open fractures beyond grade II beyond tendon injuries, punch press. 2. Revision Surgery – Documentation of presence of scarring, complex tissue defects. Non-union of fracture, and fusion. Scarring of joint and adhesions. Required lysis of scar to mobilize nerves and joints. Correction of instability / deformity resulting from prior surgery. 3. Morbid Obesity – BMI => 40 (wt / ht x 704.5 = BMI) Affects wound healing, fusion, rehabilitation, outcome measures	125 percent of fee schedule amount. Appropriate documentation includes cover letter and/or photos for documentation.
23	Please refer to CPT.	125% of fee schedule amount when documented that procedure required general anesthesia.
24	Please refer to CPT.	Lesser of charge or fee schedule amount for E/M service.
25	Please refer to CPT.	Separate payment is made at the lesser of the charged amount or fee schedule amount according to CPT description. Modifier 25 allows separate payment for services without requiring documentation with the claim form.
26	Please refer to CPT.	Fee schedule recognizes modifier and adjusts payment accordingly – no further adjustments are needed.

Modifier	AMA Description/Illinois Instructions	Payment Policy/ Documentation Requirements
32	Please refer to CPT.	Lesser of charge or fee schedule amount.
47	Please refer to CPT.	Lesser of charge or fee schedule amount.
50	Please refer to CPT. Appropriate Usage for Modifier 50: When the procedure is done bilaterally **AND** the Payment Guide indicator (BILT SURG) for the procedure is "1," report the procedure code once; append with modifier 50 and report with one unit of service. This modifier is only appropriate when the service performed on two bilateral body parts. Inappropriate Usage for Modifier 50: Reporting this modifier when the service is performed on different areas of the same side of the body. The BILT SURG indicator is 0, 2, 3, or 9. When removing a lesion on the right arm and one of the left arm. On a procedure code that is described as bilateral in its CPT description.	150% of the fee schedule amount.
51	Please refer to CPT. Appropriate Usage of Modifier 51: When the same physician performs more than one surgical service at the same session. When procedure codes have an indicator of "2" or "3" (MULT SURG) in the Payment Guide chart. Append modifier 51 to the additional services performed. Be sure that it is appended to the procedure code with the lower allowed amount. Inappropriate Usage of Modifier 51: Do not use with designated add-on codes. Reporting modifier 51 on ALL lines of service. Multiple surgery pricing logic applies to bilateral services (modifier 50) that are performed on the same day with other procedures. Multiple surgeries are ranked based on allowed amount, not the billed amount.	Lesser of the actual charge or 100% of the fee schedule amount for the procedure with the highest payment. Payment of the second through fifth surgical procedures is based on the lesser of 50% of the actual charge or 50% of the fee schedule amount. Surgical procedures beyond the fifth are priced on a "by-report" basis. This payment policy should also apply to multiple endoscopic procedures.

Modifier	AMA Description/Illinois Instructions	Payment Policy/ Documentation Requirements
52	Please refer to CPT.	Lesser of charge or 76% of fee schedule amount.
53	Please refer to CPT.	Lesser of charge or 76% of fee schedule amount.
54	Please refer to CPT. Modifier 54 is used to indicate that the surgeon is billing for only the surgical care and another physician is providing all or part of the postoperative care. Appropriate Usage of Modifier 54: When all or part of the postoperative care is relinquished to a physician who is not a member of the same group. Appended to the procedure code that describes the surgical procedure performed that has a 10 or 90-day postoperative period. Inappropriate Usage of Modifier 54: Appending modifier 54 to a surgical procedure without a global period. Appending this modifier to an E/M procedure code.	Lesser of charge or fee schedule amount and documentation of service.
56	Please refer to CPT.	Lesser of charge or fee schedule amount for pre-operative services based on E/M codes.
57	Please refer to CPT.	Separate payment for the lesser of the actual charge or the fee schedule amount is to be made for the visit at which the decision to perform the surgery was made.
58	Please refer to CPT.	Payment is made at the lesser of the charged amount or fee schedule amount for the staged or related procedure.

Modifier	AMA Description/Illinois Instructions	Payment Policy/ Documentation Requirements
59	Please refer to CPT. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. Appropriate Usage of Modifier 59: The physician may need to indicate that a procedure or service was distinct or separate from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site, separate session, or separate injury (or area of injury). In the situation described above, the 59 modifier may be used with the secondary, additional or lesser procedure. Inappropriate Usage of Modifier 59: The 59 modifier may <u>not</u> be <u>submitted with</u>: E/M Codes When you do not have supporting documentation of separate and distinct status. When billing for the exact same procedure code performed twice on the same day. The 59 modifier should <u>only</u> be <u>used if no other valid modifier is available</u> to identify the services.	Lesser of charge or fee schedule amount and documentation of service.
62	Please refer to CPT. Co-Surgeons – Modifier 62 Global surgery roles apply to each of the physicians participating in a co-surgery. Reimbursement is at 75% of the global surgery fee schedule amount for co-surgeons. If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure, and both surgeons need to use the same codes. The following Payment Guide indicators identify services for which two surgeons, each in a different specialty, may be paid: 0 = Co-surgeons not permitted for this procedure. 1 = Co-surgeons may be paid if supporting documentation is supplied to establish medical necessity. 2 = Co-surgeons permitted. No documentation is required if two-specialty requirement is met.	Total payment will equal 150% of the lesser of the charged amount or fee schedule amount for the surgical procedure(s) performed, to be divided equally between the co-surgeons.

Modifier	AMA Description/Illinois Instructions	Payment Policy/ Documentation Requirements
66	Please refer to CPT. Team Surgeons – Modifier 66 Global surgery rules apply to each of the physicians participating in a team surgery. Reimbursement is determined "By Report." If a team of surgeons (more than two surgeons of different specialties) is required to perform a specific procedure, each surgeon bills for the procedure with a modifier "-66." The following Payment Guide indicators identify services for which team surgeons may be paid: 0 = Team surgeons not permitted for this procedure. 1 = Team surgeons may be paid if supporting documentation is supplied to establish medical necessity of a team. Pay by report. 2 = Team surgeons may be paid. Paid by report.	Each individual surgeon is paid lesser of charge or fee schedule amount. Documentation for medical necessity is required.
76	Please refer to CPT.	Physician is paid lesser of charge or fee schedule amount.
77	Please refer to CPT.	Physician is paid lesser of charge or fee schedule amount.
78	Please refer to CPT.	Surgeon is paid lesser of charge or fee schedule amount.
79	Please refer to CPT.	Surgeon is paid lesser of charge or fee schedule amount.
80 81 82	Please refer to CPT. An "assistant at surgery" is a physician who actively assists the physician in charge of a case in performing a surgical procedure. The "assistant at surgery" provides more than just ancillary services.	For 80: Lesser of actual charge or 20% of fee schedule amount. For 81: Lesser of actual charge or 15% of fee schedule amount. For 82: Lesser of actual charge or 20% of fee schedule amount.
90	Please refer to CPT.	Lesser of charged amount or fee schedule amount - and provision of documentation.
91	Please refer to CPT.	Lesser of charge or fee schedule amount.

Section 9. Allied Health Care Professionals

Allied health care professionals such as certified registered nurse anesthetists (CRNAs), physician assistants (PAs) and nurse practitioners (NPs) will be reimbursed at the same rate as all other health care professionals when performing, coding and billing for the same services.

Section 10. Correct Coding

The fee schedule requires that services be reported with the HCPCS/CPT codes that most comprehensively describe the services performed. The Commission incorporates the National Correct Coding Initiative (NCCI) as the review standard as it relates to bundling edits, and prohibits any proprietary bundling edits more restrictive than the NCCI. The NCCI is contained in the National Correct Coding Policy Manual in Comprehensive Code Sequence for Part B Medicare Carriers, Centers for Medicare and Medicaid services, Version 12.0, 2006.

Section 11. Independent Diagnostic Testing Facilities

All fees from independently operated diagnostic testing facilities will be subject to the professional services and HCPCS fee schedules.

Section 12. Out-of-State Treatment

For out-of-state medical services on Illinois workers' compensation claims, reimbursement will be the greater of 76% of the charged amount or the amount set forth in a workers' compensation medical fee schedule adopted by the state in which the procedure, treatment or service is rendered, if such a schedule has been adopted.

Facility fees will be paid at 65% of charged amount for prosthetics/orthotics, pacemaker, lens implants, implants, ambulance, investigational devices and drugs requiring detailed coding. See Sections 1, 6 and 7 above for additional information on facility fees.

All charges for out-of-state treatments are subject to the other instructions and guidelines in this fee schedule.